Appendix

Appendix 11

Sample Completed Prior Authorization Durable Medical Equipment Attachment (PA/DMEA)

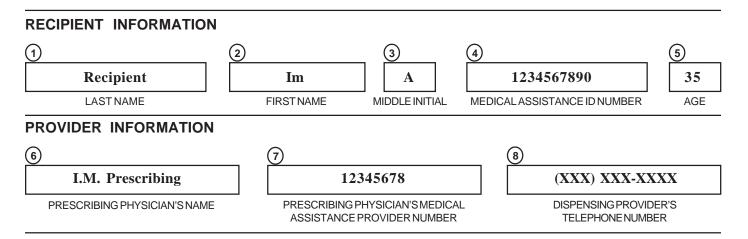
Mail To:

Wisconsin Medicaid **Prior Authorization Unit** Suite 88 6406 Bridge Rd. Madison, WI 53784-0088

PA/DMEA

PRIOR AUTHORIZATION **DURABLE MEDICAL EQUIPMENT ATTACHMENT**

- 1. Complete this form.
- 2. Attach to PA/RF. (Prior Authorization/Request Form)
- 3. Mail to Wisconsin Medicaid.



A. Describe the overall physical status of the recipient: (mobility, self-care, strength, coordination)

Is independent in mobility and self cares. Shows adequate and normal strength and coordination.

B. Describe the medical condition of the recipient as it relates to the equipment/item requested — Why does the recipient need this equipment?

Has Type 1 diabetes, was recently in good control with BID testing of blood sugars. Recent bladder infection, currently on antibiotics. Physician ordered additional testing. Increased to 5x's per day.

- C. Is the recipient able to operate the equipment/item requested \(\mathbb{\text{M}}\) Yes \(\mathbb{\text{P}}\) No if not, who will do this? **Independent**
- D. Is training provided or required? ☐ Yes X No Explain: Recipient previously instructed on proper glucometer use. Demonstrates good technique.

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	State where equipment Manch type, NO accessib	e of dwelling and a	ccessibility)				
Ιζ	☐ Nursing Home	□ School	☐ Office	□ Job			
	(Describe type of c	dwelling and access	SIDIIITY)				
	Attach an Occupationa of applicable.	l or Physical Thera	ipy Report if ava	ailable.			
	State estimated duration months. Once infection		ecrease to BID	testing.			
 H. If renewal or continuation of DME Authorization is requested, describe the recipient's Current clinical condition Progress (improvement; no change, etc.) Results Recipient's use of equipment/item prescribed 							
In	Initial PA request, not applicable.						
I.	Indicate amount of oxyg	gen to be administe	ered: Not appli	cable.			
	Liters per minute	Continu	ious				
	Days per week	PaO ₂					
Attach a photocopy of the Physician's Prescription to this Attachment form. The prescription must be signed and dated within 6 months of receipt by Wisconsin Medicaid.							
	THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).						
	MAN IDD NAVANA		I.M. Pra	our daz.			
J.	MM/DD/YYYY Date		Requesting Provide	r's Signature			